PACK Program Design Review Team

Meeting 3

March 13th, 2024

Agenda

1. Welcome and Introductions
2. Meeting 2 Recap
3. Future State Measures
4. Looking Ahead
5. Questions

1. Welcome and Introductions

Meet the PACK Team

Devin Kepler
PACK Lead

Dr. Katie Price
Pediatric Consultant

Suman Mathur
Design Review Team Facilitator

Emily Leung
Design Review Team Co-Facilitator

Samantha Block
PACK Support Team

Andy Wilson
PACK Support Team

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Design Review Team Introductions

- If you joined the last DRT Session, please reintroduce yourself in the chat with:
  - Your name and organization
- If you are joining us for the first time:
  - Your name
  - Name of your organization and role
  - Your involvement in previous APM programs (if applicable)
  - Why did you want to be involved in the Design Review Team?

2. Meeting 2 Recap

Activity 1: Icebreaker

What we heard

- DRT members generally agreed that the goals and objectives address what is important.
- DRT members recommended additional focus on health related social needs, financial sustainability, and member experience within goals.
- Updates to goals and objectives will be presented later in this presentation.

Approval of Meeting Minutes

- Are there any proposed changes to meeting minutes from Meeting 2?
- Any objections to posting a de-identified, abbreviated version of this document to the HCPF website (publicly accessible)?
- Once approved, meeting minutes will be posted on the PACK webpage.

PACK North Star

Every child and adolescent with Health First Colorado has the opportunity for a healthy childhood via equitable engagement with a primary care medical provider which is pediatric wellness-focused. This provides access to the prevention and management of illness, injury, and behavioral health services which maximizes the physical, developmental, and behavioral outcomes of every child and adolescent member.

The Design Review Team will provide iterative feedback to HCPF on key design topics

✓ 1. **Goals and Objectives:** What are we trying to achieve?
2. **Quality Measurement and Quality Target Setting:** How will (quality) performance be measured for both informational and payment purposes?
3. **Payment:** What adjustments to payment are needed to adequately support high-value care delivery? What is the mechanism of how providers will be paid?
4. **Performance Improvement:** What information do you need to be successful?
5. **Program Sustainability:** What types of support will be needed to sustain this program?

3. Future State Measures

What can measures be used for?

1. To tie to payment
2. To evaluate and track program success
3. To support continuous improvement activities for providers
4. To support member choice

Measure Selection Considerations

1. Align with industry standards and other programs
2. Link back to program goals
3. Measures are statistically reliable and valid

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1. Measures will align with industry standards and other programs, including but not limited to

- Centers for Medicare and Medicaid Services Child Core Sets
- Colorado Division of Insurance
- HCPF Health Equity Plan
- CMS Innovation Model (CMMI) Making Care Primary

- Accountable Care Collaborative Phase III KPI
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Agency for Healthcare Research and Quality
- Federally Qualified Health Centers (FQHC)– Health Center Program Uniform Data System (UDS)
- HCPF Hospital Transformation Program (HTP)

1. Measures will align with industry standards and other programs

Colorado APM Alignment Initiative

House Bill 22-1325 – Primary Care APMs

Colorado Insurance Regulation 4-2-96

Colorado Insurance Regulation 4-2-96: Aligned Quality Measure Set (Pediatric Measure Set)

Domain	Measure	CBE ID/Steward
Preventive Care	Child and Adolescent Well-Care Visits	1516 / NCQA
Preventive Care	Developmental Screening in the First Three Years of Life	1448 / OHSU
Preventive Care	Well-Child Visits in the First 30 months of Life	1392 / NCQA
Preventive Care	Screening for Depression and Follow-Up Plan	0418 / CMS
Preventive Care	Childhood Immunization Status	0038 / NCQA
Preventive Care	Immunizations for Adolescents	1407 / NCQA
Patient Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC) - OR – Person-Centered Primary Care Measure (PRO-PM)	0006 / AHRQ 3568 – American Board of Family Medicine

Source: Colorado Insurance Regulation: Appendix 3 CCR 702-4-2-96-C Aligned Quality Measure Sets

Measure Selection Considerations

1. Align with industry standards and other programs
2. Link back to PACK goals
3. Measures are statistically reliable and valid

2. Measures will link back to PACK goals

Our focus for today

North Star
Each element of the PACK North Star relates to the HCPF North Star

PACK Goals
Linked back to the North Star: the "what (are you trying to achieve)"

Objectives
Supporting Objectives of PACK Goal: the "how"

Measures
How do we measure success of the PACK goals/objectives?

HCPF North Star

PACK North Star

01

02

03

04

05

06

For discussion:

For each objective, the State has identified measures from the Department of Insurance (DOI) Regulation 4-2-96 – Pediatric Measure Set (from Slide 18) that may potentially be tied to payment.

What additional measures should the State consider to support:

- Evaluating and tracking program success
- Continuous improvement activities for providers

Goal 1: Improve physical outcomes for child and adolescent members
Measures for consideration

What other measures should the State consider to support:
- *Evaluating and tracking program success*
- *Continuous improvement activities for providers*

Objective		Measure(s)	
Objective	Increase well-child visits	Measure(s)	• *Well-Child Visits in the First 30 Months of Life Measure (W30)** • *Child and Adolescent Well-Care Visits: Ages 3 to 21 (WCV)* • TBD
Objective	Increase immunization rates	Measure(s)	• *Childhood Immunization Status (CIS)*** • *Immunizations for Adolescents (IMA)*** • TBD

Measure potentially tied to payment

Measures TBD: Informational Only

**W30 includes :1) Well-Child Visits in the First 15 Months: Children who turned age 15 months during the measurement year: six or more well-child visits and 2) Well-Child Visits for Age 15 Months-30 Months: Children who turned age 30 months during the measurement year: Two or more well-child visits. Retrieved from link.*

***Immunization Combination selection is still being determined*

Goal 2: Improve developmental and behavioral outcomes for child and adolescent members

Measures for consideration

What other measures should the State consider to support:

- *Evaluating and tracking program success*
- *Continuous improvement activities for providers*

Objective	Increase number of Bright Futures' recommended screenings

Measure(s)	• *Developmental Screening in the First Three Years of Life (DEV)* • *Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF)* • TBD

Measure potentially tied to payment

Measures TBD: Informational Only

Goal 3: Reduce disparities for key primary care outcomes across the state

Measures for consideration

What other measures should the State consider to support:
- *Evaluating and tracking program success*
- *Continuous improvement activities for providers*

Objective		Measure(s)
Objective	Reduce racial and ethnic disparities for well-child visits, immunizations, and screenings	Measure(s)
Objective	Reduce geographic disparities for well-child visits, immunizations, and screenings	Measure(s)
Objective	Reduce socioeconomic disparities for well-child visits, immunizations, and screenings	Measure(s)

By racial/ethnic disparities, geographic, socioeconomic disparities:

- Well-Child Visits in the First 30 Months of Life Measure (W30) *
- Child and Adolescent Well-Care Visits: Ages 3 to 21 (WCV)
- Childhood Immunization Status (CIS)**
- Immunizations for Adolescents (IMA)**
- Developmental Screening in the First Three Years of Life (DEV)
- Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF)
- TBD

Measure potentially tied to payment

Measures TBD: Informational Only

**W30 includes :1) Well-Child Visits in the First 15 Months: Children who turned age 15 months during the measurement year: six or more well-child visits and 2) Well-Child Visits for Age 15 Months-30 Months: Children who turned age 30 months during the measurement year: Two or more well-child visits. Retrieved from link.*

***Immunization Combination selection is still being determined*

Goal 4: Increase access to pediatric primary care for child and adolescent members
Measures for consideration

What other measures should the State consider to support:
- *Evaluating and tracking program success*
- *Continuous improvement activities for providers*

Objective	Increase the capacity of pediatric primary care for child and adolescent members

Measure(s)	TBD

Measure potentially tied to payment
Measures TBD: Informational Only

Goal 5: Improve member and family experience
Measures for consideration

What other measures should the State consider to support:

- *Evaluating and tracking program success*
- *Continuous improvement activities for providers*

Objective	Improve the relationship between the member and family and their pediatric primary care setting	Measure(s)	• Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC)* • Person-Centered Primary Care Measure (PRO-PM)* • TBD

Measure potentially tied to payment

Measures TBD: Informational Only

*Exploratory, not final measures

Goal 6: Develop a pediatric VBP program that is sustainable for both providers and HCPF
Measures for consideration

What other measures should the State consider to support:
- *Evaluating and tracking program success*
- *Continuous improvement activities for providers*

Objective	Improve pediatric provider and practice staff experience	Measure(s)	• TBD
Objective	Minimize provider administrative burden	Measure(s)	• TBD
Objective	Create model design which is operationally efficient and financially sustainable for both HCPF & providers	Measure(s)	• TBD
Objective	Provide health information technology tools for PCMPs that provide actionable insight into performance	Measure(s)	• TBD
Objective	Increase adoption of pediatric-specific practice transformation in all primary care settings that care for child and adolescent members	Measure(s)	• TBD

Measure potentially tied to payment
Measures TBD: Informational Only

Measure Selection Considerations

1. Align with industry standards and other programs
2. Link back to program goals
3. Measures are statistically reliable and valid

4. Looking Ahead

What's Next?

- **Next DRT Session:** Wednesday, March 27th from 5:00pm – 7:00pm
- **Resources** available for your review:
  - Team Charter
  - PACK Program Resources
- **Questions?** Please email us at HCPF_VBPStakeholderEngagement@state.co.us

5. Questions?

Thank you!

Appendix 1: DRT Materials

Upcoming PACK DRT Meeting Topics

Date	DRT Meeting	APM Framework Component	PACK DRT Meeting Topic (Subcomponent)
Feb 7	1	DRT Overview	Meetings, Expectations, Background
Feb 28	2	Goals and Objectives	Feedback on Goals
Mar 13 – Today!	3	Quality Measurement & Quality Target Setting	Feedback on Quality Measures
Mar 27	4	Quality Measurement & Quality Target Setting	Feedback on Quality Measures
Apr 10	5	Payment	Overall process of payment setting
Apr 24	6	Payment	Feedback and proposed considerations for attribution method
May 8	7	Payment	Feedback, pros, cons for risk adjustment methodology considerations
May 22	8	Payment	Overall process of reconciliation
June 12	9	Performance Improvement	Actionable insights, provide ‘must haves’, nice to haves
June 26	10	Program Sustainability	Prioritize types of Support

Reminder: Health First Colorado Member Compensation

- You have two options to receive compensation:
  1. Online Tango Card Gift Card
  2. Direct Deposit (requires filling out a W-9)

- You will be paid monthly for your time at a rate of $30 per hour. Instructions on how to submit a monthly timesheet will be sent via email.

- Monthly Office Hours started in March.

Appendix 2: Centers for Medicare & Medicaid Services (CMS) Core Measures

CMS Core Measures

Technical Specifications to the CMS Child Core Measures can be found here.
Note: This document reviews all CMS Core Measures, but as a reminder only the Pediatric Measure Set (Slide 18) will be potentially tied to payment.

Measure	Page Number
Child and Adolescent Well-Care Visits	133
Developmental Screening in the First Three Years of Life	71
Well-Child Visits in the First 30 months of Life	125
Screening for Depression and Follow-Up Plan	54
Childhood Immunization Status	61
Immunizations for Adolescents	92
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC)	68

Appendix 3:
APM 1 Overview

APM 1 Overview

The APM 1 uses a **points-based** system to measure provider performance.

Step 1: Measure Selection	Step 2: Performance Year	Step 3: Rate Adjustment
Each Primary Care Medical Provider (PCMP) is **responsible for 10 quality measures** each year: three mandatory, and seven self-selected.	PCMPs earn points by **reporting** on the selected measures and **demonstrating high performance or improvement.**	The number of points earned by each PCMP determines the **rate change** for that practice.

Repeat

Measure Calculations

Providers earn points differently for each measure type.

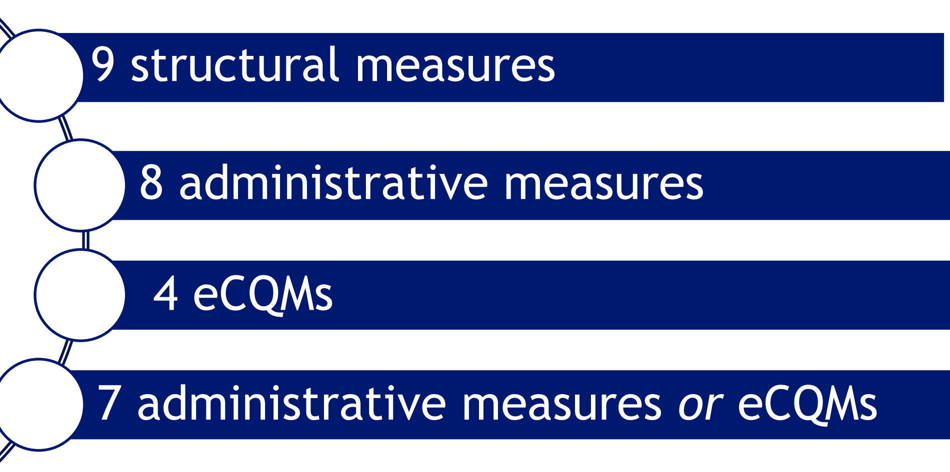
Structural Measures:

- Pass/fail: Practices earn all or none of the measure's points based on documentation.

Administrative Measures and eCQMs:

- Earn points based on **Close the Gap** calculation demonstrating improvement between a practice's baseline performance and HCPF's target goal for the measure;
  or,
- Earn full points if the target goal for the measure is achieved.

PY2023 Measure Set



- **Measure choice:** Some measures are available as either administrative or eCQM; PCMPs can choose which type works best for the practice.
- **Structural point limit:** Non-FQHC PCMPs cannot earn more than 100 points from structural measures.

Close the Gap Calculation

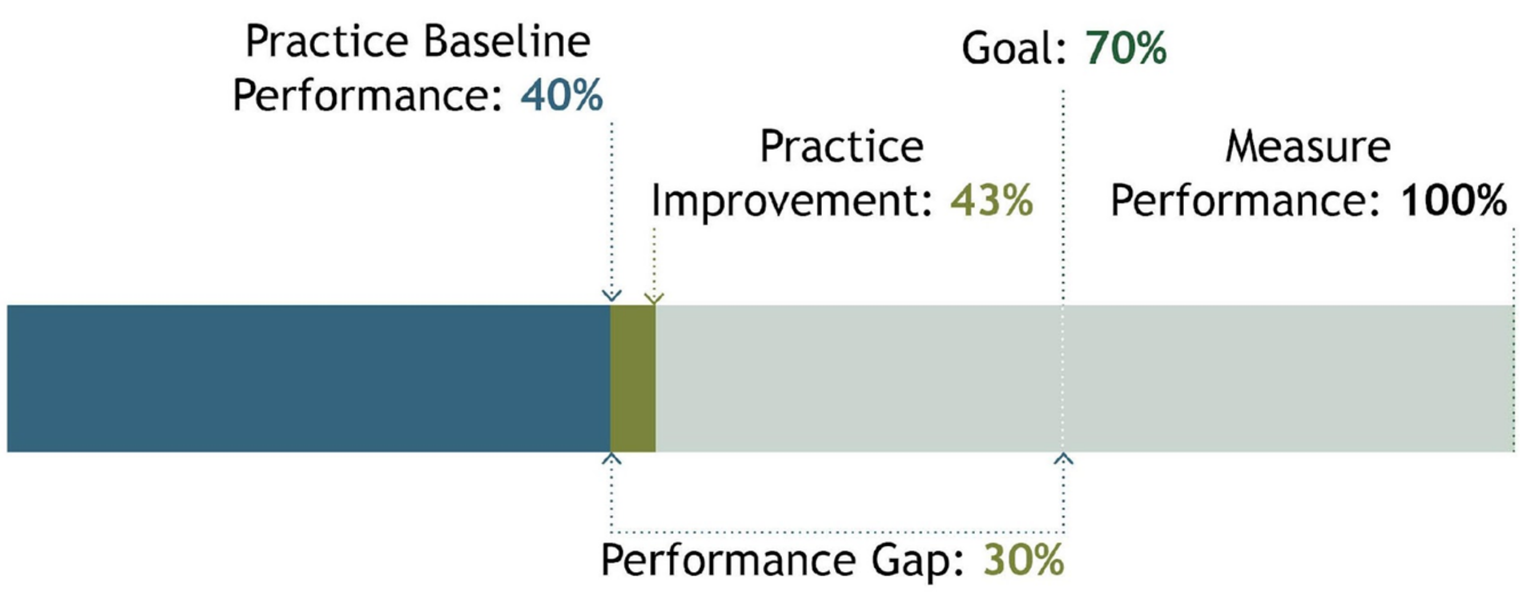


Image description: HCPF sets a goal of 70%. The primary care practice begins with a baseline of 40%. This leaves a performance gap of 30 percentage points. The practice improves by 3 percentage points in the next year. That earns the practice points for closing 10% of its performance gap.

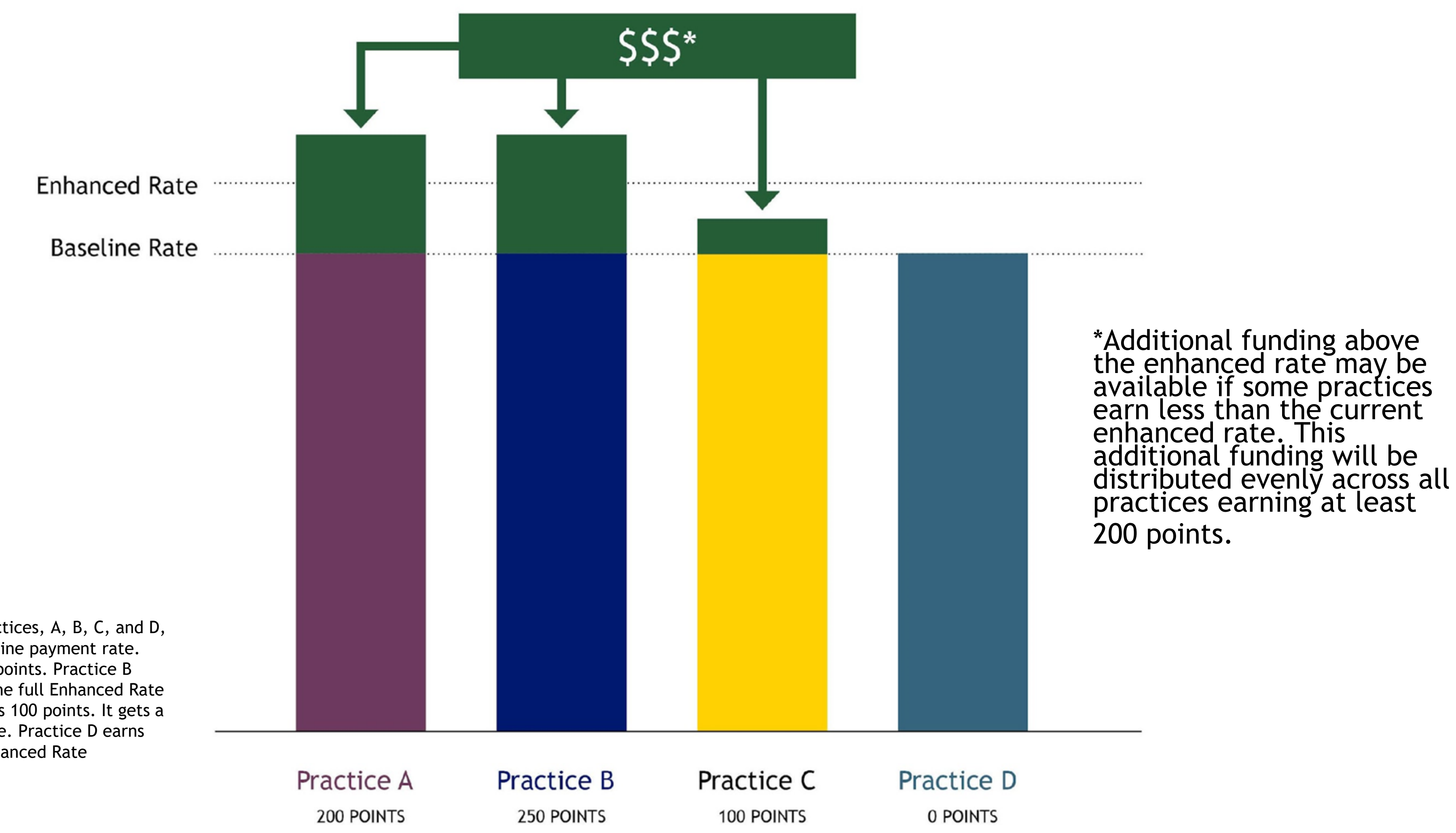
Payment Model: Rates

Beginning October 2022, enhanced rates were tied to APM quality scores.

APM Quality Score Range	Enhanced Rate
151 to 200	>3% to 4% (+)
101 to 150	>2% to 3%
51 to 100	>1% to 2%
0 to 50	0 to 1%

(+) Practices who achieve an APM Quality Score of at least 200 points may receive a rate increase of more than 4% in years when additional funding is available.

Payment Model: Distribution



*Additional funding above the enhanced rate may be available if some practices earn less than the current enhanced rate. This additional funding will be distributed evenly across all practices earning at least 200 points.

Image description: Four practices, A, B, C, and D, all start with the same baseline payment rate. Practice A earns 200 APM 1 points. Practice B earns 250 points. Both get the full Enhanced Rate from APM 1. Practice C earns 100 points. It gets a portion of the Enhanced Rate. Practice D earns no points, and it gets no Enhanced Rate payments.

Health First Colorado Member Performance

Medicaid-Only eCQM Reporting

- Effective PY2023, HCPF required PCMPs to report supplemental eCQM data specific to the Health First Colorado population.
- HCPF will continue to pilot Medicaid-only eCQM reporting for the upcoming program year (PY 2024).

This data will be used to determine the **ability and viability** for PCMPs to report eCQMs versus administrative measures in future program years.

Medicaid-Only eCQM Reporting

- Use PY2024 to work with Contexture and QHN to set up reporting
- PCMPs **must** submit supplemental Medicaid-only eCQM data in PY2024

This data will be used to determine the **ability and viability** for PCMPs to report eCQMs versus administrative measures in future program years.

Appendix 4: APM 1 Current State Quality Measures

Types of Measures

Structural Measures. Focus on a practice's capacity, systems, and processes to provide high-quality care.

- Provided and calculated via attestation form administered by the RAE.

Administrative Measures. Indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a chronic health condition.

- Provided and calculated via state agency data and claims data.

Electronic Clinical Quality Measures (eCQMs). Reflect additional detail beyond the claim files showing the impact of the health care services or interventions on the health status of patients.

- Provided and calculated via electronic medical record (EMR).

PY2023 Quality Measures

Steward	Measure #	Measure	Category
CMS	NQF 0418/ CMS 2	Screening for Depression and Follow-Up Plan	Mandatory 3 Adult (Admin/eCQM)
NCQA	NQF 1800	Asthma Medication Ratio	Roll-In 1 All (Admin)
NCQA	NQF 0105/ CMS 128	Antidepressant Medication Management	Roll-In 1 Adult (Admin/eCQM)
NCQA	NQF 0032/ CMS 124	Cervical Cancer Screening	Roll-In 2 Adult (Admin/eCQM)
NCQA	NQF 0033/ CMS 153	Chlamydia Screening for Women	Roll-In 3 Adult (Admin/eCQM)
NCQA	NQF 2372/ CMS 125	Breast Cancer Screening	Adult Set (Admin/eCQM)
N/A	CMS 130	Colorectal Cancer Screening	Adult Set (eCQM)

Steward	#	Measure	Category
CMS	CMS 69	Body Mass Index (BMI) Screening and Follow-Up	Adult Set (eCQM)
NCQA	NQF 3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Adult Set (Admin)
NCQA	NQF 0576	Follow-Up After Hospitalization for Mental Illness	All (Admin)
N/A	N/A	Alternative Encounters	All (Structural)
N/A	N/A	Availability of Appointments	All (Structural)
N/A	N/A	Behavioral Health Integration	All (Structural)
N/A	N/A	Emergency Department & Hospital Follow Up	All (Structural)
N/A	N/A	Improving Patient/Family Access	All (Structural)
N/A	N/A	Individual Care Plan	All (Structural)
N/A	N/A	Interdisciplinary Team	All (Structural)
N/A	N/A	Patient Satisfaction	All (Structural)
N/A	N/A	Referral Tracking	All (Structural)
CMS	CMS 165	Controlling High Blood Pressure	Back Up 2 Adult (eCQM)
CMS	CMS 122	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	Back Up 1 Adult (eCQM)
N/A	N/A	Comprehensive Diabetes Care: Hemoglobin (HbA1c) Testing	Mandatory Adult 1 (Admin)

Source: ACC APM 1 - Measure Set Program Year 2023